# ALBERTA HEALTH AND WELLNESS
## *Review of Bill 11 Assessment Criteria*

## General Observations

The legislative requirements of Bill 11 (referred to as the Act) are generally well matched by the Assessment Criteria publicly released by the Minister of Health and Wellness on July 24, 2000. It is evident that significant and constructive effort has already been invested to-date and the document is comprehensive. The findings of this review are recommendations for improvement.

There are two subjects within the Act that warrant consideration for changes within the Criteria:

- The Act (Section 3) seeks to avoid people being able to jump a waitlist queue to receive preferential treatment. The Criteria need to be clear on this point, particularly under Access section 8(3)(a) ***Accessibility***. We recommend making this a stand-alone point.

- From our understanding of its intent, the Act seeks a transparent process and contract that is without real or apparent conflict for key parties to the contract. Currently "conflict of interest" is directly referenced for physicians, but not for Health Authority (HA) board members and staff. Direct reference to board members and staff is recommended to exclude involvement in the decision-making process.

In a number of criteria the wording used calls for a contractor to provide service at least equal to that available in a public HA facility. This standard may be limited for some services and we recommend a broader standard, such as including relevant generally accepted standards of quality in patient care.

We note that many of the current contracts are relatively modest. Many contractors will not have the size of operation required to support the full range of services provided in a public acute care hospital. The legislative expectation is for HAs to work with contractors to provide patients with pre and post surgical services such as diagnostic services and home care services. We recommend the criteria clearly reflect the need for contractor services to be fully coordinated with HA services.

We are very aware that admittedly this is the first example in Canada of the establishment of criteria for contracted health services. Thus a key subsequent issue to be addressed is how the criteria will be operationalized. The criteria as reviewed are effectively a framework and not yet a process. The operational process, although it is beyond the scope of this review, will need to be practical and easily administered. We recommend that an annual post implementation evaluation of the approval process, the criteria and the outcomes achieved be considered and that the evaluation results be used to make further adjustments as appropriate. We also recommend that the Health Authorities work together to establish consistency with respect the look and feel of operational criteria.

## Specific Observations and Recommendations

The following content refers only to specific sections where the wording of a Description or Criterion may be enhanced to meet the legislative requirement and/or clarification to the wording is recommended.

Section 8 (a) ***Portability & Accessibility***: We recommend that language be added to the Criteria to ensure all patients, including those from outside Alberta, are treated in accordance with the Canada Health Act and existing inter-provincial reciprocal billing agreements.

Section 8(3)(c) ***Ownership and Transfer of Agreement***: The legislative requirement seeks to avoid having an "... adverse impact on the publicly funded and publicly administered health system ...". Presumably the "adverse impact" includes minimizing possible legal liability, particularly through a transparent process based on good information. However, legal liability is not directly addressed and you may wish to consider specifically addressing this area.

***Risk of Dependency***: Contracting out a significant portion or all of an HA's needs for insured services to a single contractor could create a monopoly for these services and make it difficult to sustain alternatives (e.g., in public sector, acute care hospitals) over the long term. There are several issues that need to be anticipated in the criteria in this section or in the contract.

A significant issue is the potential risk of a contractor failing and leaving the HA without services. It seems prudent and reasonable that the contractor must provide the HA assurance of their ongoing financial viability at the beginning of any contract period. It also seems reasonable that this sensitive and detailed information should be kept confidential by the HA. We would fully expect that existing risk management protocols in the Health Authorities would be applied.

We note that the notice period for contract termination under normal circumstances needs to be of sufficient length that the HA can repatriate and re-establish services smoothly either themselves or with a new contractor. This period will vary depending on the type of service being provided.

***Workforce Issues***: We recommend changing the wording of the description to the following; "The health workforce available to the public must continue to have the ability and expertise to deliver medically necessary services in the overall health system."

***Other Factors***: The tie-in between the description under this point, which is general, and the criteria, which are specific, is awkward. We recommend the wording be changed to clarify and improve the connection.

Section 8(d) ***Public Benefit***

Section 8(d)i ***Access***: Note the earlier general observations about the need to ensure no preferential access and to clarify access by non-Albertans for elective and emergent contracted services.

Section 8(d)ii ***Service Quality***

Adding a descriptive paragraph that introduces the five components of quality standards is recommended to assist clarifying this section.

***Quality: Acceptability***: Although the criteria are silent, presumably the first response to a patient and family concern will be with the contractor, particularly if the concern is about the process or quality of care. Other concerns such as a patient being billed for extra costs by a contractor may appropriately be directed immediately to the HA. Linking a patient's concern with the HA's internal resolution process may have legal consequences or shift legal responsibility to the HA from the contractor. While it is vital for the HA to monitor the contractor's patient concerns and satisfaction, creating a practical means for this will need careful attention. It may require a different resolution process. We recommend the wording and criteria be clarified to ensure roles and responsibilities are appropriate.

***Quality: Effectiveness***: The criterion requires reporting on the health outcomes achieved. This is an admirable objective. However, contractors and public facilities alike may have difficulty identifying and therefore complying with measurable and meaningful longer-term health outcomes. An ongoing evaluative process may assist in achieving this objective over time.

Section 8(3)(d)(v) ***Cost Effectiveness***: The options included in the criteria refer to building a new facility. There will be additional one-time and ongoing costs in addition to the building itself that need to be considered and they include items such as capital equipment, furnishings and interior finishes, and commissioning. It is recommended that these criteria be expanded to reflect achieving an "operating facility".

Section 8(3)(f) ***Performance***: the second of the two criteria is a "process to monitor expectation has been defined". Presumably what is needed is to monitor expectations against results achieved for performance measures that will be specified in the first criterion. We recommend the two criteria be merged and the intent clarified.